

Key Elements of the Affordable Care Act:

Interface With Correctional Settings and Inmate Health Care



Executive Summary

- Coverage for children up to age 27: This change may create new challenges in billing for on-site services but also presents a savings opportunity for off-site admissions.
- Medicaid expansion: Most, if not all offenders, will now be eligible for Medicaid. Incoming offenders who were previously Medicaid eligible will have records that will be helpful to obtain. Off-site inpatient admissions will be covered by Medicaid. Inmates will be Medicaid eligible upon release giving them health care coverage and access to support services.
- Mental health parity: Mental health and substance abuse treatment services will be provided at parity immediately upon release, thereby aiding the reentry process.

Introduction

Congress passed landmark legislation in March 2010 setting forth a massive package of health care reforms. The Patient Protection and Affordable Care Act (herein referred to as “the Affordable Care Act”) provides health care coverage to 31 million of the country’s 52 million uninsured, reforms the insurance markets in each state, establishes health insurance exchanges in every state where individuals and small businesses can shop online for health insurance, and sets forth many research and demonstration projects to reform virtually every corner of the health care industry. Most of the major provisions of the Affordable Care Act take effect in January 2014, but some have already begun.

Understanding the key elements of the Affordable Care Act and how it will affect corrections and correctional health care is critical as planning and implementation progress. Whether a state supports or opposes the Affordable Care Act, insurance exchange and Affordable Care Act implementation planning is currently being conducted – with or without input from corrections. Several provisions of the act have direct and indirect effects on the corrections profession, inmate health care and reentry provisions, thereby making it essential that correctional leaders carefully engage their state governments and community partners.

In December 2011, the Department of Health and Human Services released a bulletin clarifying that states would have the flexibility to select an existing health plan to set the “benchmark” for the items and services included in the essential health benefits package in their respective state. States would have the flexibility to select a plan that would be equal in scope to the services covered by a typical employer plan in their state as long as the essential health benefits package covers items and services in at

least 10 categories of care, including preventive care, emergency services, maternity care, hospital and physician services, and prescription drugs.

In 2012, there are a few important landmarks regarding the enactment of the Affordable Care Act. On Jan. 1, implementation incentives became available for physicians to form “affordable care organizations” designed to improve care and reduce unnecessary hospital admissions. Groups that improve care and reduce costs will be able to retain some of the money saved. On Oct. 1, Medicaid payments will be linked to hospital quality in an effort to improve care. Also on Oct. 1, health care providers must begin standardizing billing and implementing rules for secure, confidential, electronic exchange of health data.

The Supreme Court has agreed to take up consideration of the Affordable Care Act and individual sections of the act. The court will hear oral arguments in March of this year. Regardless of the legal challenges, it is imperative that we be well-informed and involved in the process.

This document provides an overview of the key elements of the Affordable Care Act that affect correctional organizations and inmate health care, now and in the future. The document presumes that the Affordable Care Act will be implemented as it is written; the American Correctional Association will provide updates on changes that occur as a result of court rulings or congressional actions, as they occur. While state-specific considerations will affect planning and implementation of the Affordable Care Act, this document provides basic information that correctional leaders should understand.

AFFORDABLE CARE ACT COVERAGE EXPANSIONS

Coverage for Children Up to Age 27

Effective Jan. 1, 2010, the Affordable Care Act allows young adults to stay on their parents' employer-sponsored health insurance plans until age 27. The goal of this policy is to cover as many young adults under the age of 27 as possible. Plans and issuers that offer dependent coverage¹ must offer coverage to enrollees' adult children until age 27, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. The new policy applies to both married and unmarried children, although the child's spouse and children do not qualify.

This coverage expansion applies to inmates during incarceration and at release or upon parole. Many employer-sponsored insurance plans exclude coverage during incarceration, but some do not. Departments of correction should currently be instituting processes to seek and use insurance that is available to inmates through their parents during incarceration. More aggressive exploration of existing health insurance or the availability of health insurance through family members should be explored at the entry point, by the DOC or its health care vendor. Where available, DOCs should bill applicable on-site and off-site health care to insurers.

Researching the availability of families' employer-sponsored health insurance at release or upon parole should also become part of reentry planning for inmates up to age 27, especially those who have serious mental or physical illness. Exploring family health insurance is complex, especially since many inmates' families do not live near their incarcerated children. Nevertheless, DOCs should explore and use available options. ACA will issue a technical assistance document detailing the steps to determine existing coverage, enroll inmates in Medicaid or other insurance, file claims on existing coverage, and use existing health insurance.

Medicaid Expansion

The Affordable Care Act requires that effective Jan. 1, 2014, all state Medicaid agencies significantly change eligibility criteria. Currently, most states only cover children, pregnant women, people 65 or older, and adults who are disabled, all of whom must meet state-specific income and asset levels. In 2014, the only criterion for Medicaid eligibility will be income at or below 133 percent of the federal poverty level. At that time, about 16 million people, primarily adults ages 19 – 64, will become newly Medicaid eligible.

Inmates will make up a sizeable portion of the Medicaid expansion population; each year about 9 million adults circulate through jails and about 750,000 adults are released or paroled from prisons. Of these, 40 percent of men and 60 percent of women have a combination of physical health, mental health and substance abuse conditions.

The Medicaid expansion in 2014 affects prison inmates in two important ways. First, at release or upon parole, nearly all inmates will qualify for Medicaid. As such, inmates with serious illnesses will have an immediate source of health care coverage, assuring access to prescription drugs and ongoing treatment of serious mental illness, HIV/AIDS, hepatitis, cancer, and other conditions.

Also, Medicaid federal matching funds are currently available for inpatient hospitalizations and nursing home admissions for Medicaid-eligible inmates. To date, the portion of eligible hospitalizations is relatively small. But in 2014, since the majority of inmates will qualify for Medicaid, nearly all inpatient hospitalizations and nursing home admissions will be eligible for federal matching funds. For the "newly eligible" population, i.e., most inmates, the federal match rate will be 100 percent. This is significant new revenue that can offset DOC expenses for off-site health care.

AFFORDABLE CARE ACT COVERAGE EXPANSIONS, *continued*

To date, many states have not developed mechanisms to access federal match and reduce the state's expense for inmate inpatient care. All DOCs should institute a method to collect these funds, so that in 2014 each can collect the substantial revenue available from this Medicaid expansion. ACA will issue a technical assistance document detailing the steps to engage Medicaid representatives and others in the state to enroll eligible inmates in Medicaid and collect federal matching funds for their hospitalizations and nursing home admissions.

Subsidized Nongroup Coverage

The Affordable Care Act extends affordable insurance to up to 20 million uninsured individuals. Sliding-scale premium credits will be available to people with incomes up to 400 percent of

poverty. The credits will cap premium contributions for individuals and families to about 3 percent of income at just over 133 percent of poverty² and gradually increase to 9.5 percent at 300 to 400 percent of poverty.³ Subsidized coverage can only be purchased through state-based health insurance exchanges, described below. Inmates who do not qualify for Medicaid while incarcerated will likely qualify for this subsidized coverage upon release.

¹ Certain existing employer plans do not have to provide dependent coverage until 2014 if the adult child has his or her own offer of employer-based coverage.

² 133% of poverty = \$14,404 for a single adult or \$29,327 for a family of four

³ 400% of poverty = \$43,320 for a single person and \$88,200 for a family of four

HEALTH INSURANCE EXCHANGES

The Affordable Care Act requires the establishment of state or regional health insurance exchanges to be used by uninsured individuals and small businesses. New insurance market regulations will govern health plans sold both inside and outside the exchanges, including the prohibition of rating on the basis of health, limits on how much premiums can vary based on age, no lifetime or annual limits on what a plan will pay, and no rescission of coverage when someone becomes ill.

Exchanges will provide a new, Web-based, regulated insurance marketplace. Qualified health plans sold through the exchange and those sold in the individual and small group markets will be required to provide a federally-determined essential benefit package. People purchasing coverage through exchanges will have a choice of the essential benefit package with four different levels of cost sharing: plans that cover on average 60 percent of an enrollee's medical costs (bronze plan), 70 percent of medical costs (silver plan), 80 percent of medical costs (gold plan), and 90 percent of medical costs (platinum). Out-of-pocket costs are limited to \$5,950 for single policies and \$11,900 for family policies.

The exchange will allow consumers to easily compare available plans on measures of cost, quality, provider network and benefits. Exchanges are intended to increase competition in the insurance market, and allow individuals and small business to be combined in a large risk pool. Both will reduce the cost of insurance for the uninsured and small businesses, who have only limited and costly options today.

Exchanges must use a single, simple enrollment form for all plans offered and for Medicaid eligibility. Exchanges must also link to databases that allow eligibility for plans and Medicaid to be determined electronically. Links will include the Social Security Administration, Internal Revenue Service, Immigration Services and others.

Exchanges also must contract with "navigators" who will work to support special populations to enroll in exchange-offered coverage. Federal rules and definitions for navigators have not yet been released.

States may opt out of establishing an exchange. In states that opt out, the federal government will operate the exchange. Exchange planning is under way in many states, even some of whom are actively challenging the legality of the Affordable Care Act.

DOCs will likely interface with health insurance exchanges in five ways:

- DOC inmate health care must be codified to meet international disease and treatment identification criteria (ICD9-10CM);
- DOC census data must be made available to the exchange as a component of real-time eligibility determination;
- DOCs will want the ability to enroll inmates in Medicaid or subsidized individual coverage that will be effective at release or parole, and must use the exchange to do so;
- DOCs or inmate advocate organizations may qualify as navigators and should make use of exchange navigator resources; and
- DOCs can influence the development of the single exchange application, to assure that it can be annotated where appropriate to indicate that the applicant has an active medical or mental health condition, plan of care, and a health record within the DOC.

IMPLICATIONS FOR CORRECTIONS ORGANIZATIONS

Reentry Objectives

Research has shown that access to health care upon release or parole significantly reduces recidivism, especially for inmates with serious mental illness. The coverage expansions and simplified insurance and Medicaid applications provided by the Affordable Care Act allow easy access to insurance/Medicaid coverage for inmates upon release or parole. As such, DOCs should seriously consider efforts to maximize inmate enrollment in Medicaid or insurance through the state health insurance exchange as a component of reentry planning.

However, an insurance card and a Medicaid card provide coverage but not necessarily access to a health care provider. DOCs can significantly improve an inmate's continuity of care and health care outcomes "on the outside" by including referrals to community providers into reentry planning. On a larger scale, DOCs can also engage with community mental health providers and Medicaid partners to explore seamless continuity of care for inmates upon release or parole. Additionally, states should consider a common drug formulary across prisons, jails, mental health, and Medicaid; electronic transfer of clinical records; pre-release clinical conferencing; and other strategies to assure that prescription drugs and services are readily available to the most seriously ill ex-offenders.

Also, most insurance companies and Medicaid managed care organizations have well-developed management programs for members with complex medical conditions, designed to reduce emergency room visits and improve patient outcomes. They will be very receptive to processes that advise them of new members with complex conditions who are coming to them from prison with a plan of care, medical record, and a provider who can be consulted to assure seamless transition and continuity of care.

Contracting With Health Care Vendors

DOC contracts for privatized health care services will need modifications effective in 2014 to address expectations for reentry clinical planning noted above. Modifications should include reductions in vendor compensation due to Medicaid and/or matching federal funds paid for hospitalizations.

Current and future health care vendor contracts may also address expectations for accessing parental insurance for inmates under age 27. Future health care vendor contracts should also address expectations for enrolling inmates in Medicaid or insurance through the state health insurance exchange.

Budget and Fiscal Considerations

DOCs should be aware that cost reductions expected from the use of Medicaid and parental health insurance can be estimated but not assured, and that processes to achieve these savings can require many months to set up. Accordingly, DOC leaders should take steps, if possible, such that "expected savings" are not prematurely or erroneously removed from the DOC budget.

Engaging in State-Based Exchange Planning

DOCs should determine what exchange planning is under way in the state and where it is housed, even in states that oppose the Affordable Care Act. Ideally, the DOC would be represented in the exchange planning process, to address the four areas of interest noted above. Some DOCs are already engaged in state exchange planning in this way, and are finding it very useful.

Changes in Work Processes

DOCs will need to decide what, if any, of the reentry measures described above will be adopted by the system. Where new functions will be adopted by corrections, such as enrolling or providing a way for inmates to enroll in coverage effective upon release or parole, work processes and resources will be required. A significant consideration will be how to make Internet access to the exchange available. Note that work required to enroll people in Medicaid is eligible for federal Medicaid matching funds.

Health Care Work Force Challenges

The 32 million people who will receive health insurance under the Affordable Care Act may create a significant strain on the country's primary care capacity. The most robust health care workforce development plans may not produce sufficient primary care doctors and mid-level providers or nurses to address the anticipated demand for primary care. As such, the primary care workforce available to DOCs and their vendors may be significantly strained. DOCs should immediately begin considering health care workforce recruitment and retention strategies to address this potential challenge, and should require all new health care vendor contracts to address this issue. More important, DOCs should evaluate health care process improvements that reduce health care costs, increase efficiencies, and otherwise maximize precious provider and nursing resources.

APPENDIX

At the time of the publication of this document:

- Fourteen states have already established a state insurance exchange: California, Colorado, Connecticut, Hawaii, Indiana, Maryland, Massachusetts, Nevada, Oregon, Rhode Island, Utah, Vermont, Washington and West Virginia;
- Twenty-one states have shown significant interest in establishing an exchange by passing intent legislation or have received level-one federal funding: Alabama, Arizona, Delaware, Idaho, Illinois, Iowa, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, Pennsylvania, Tennessee, Virginia and Wisconsin;
- Fifteen states have not met either criteria and have made no progress since passage of the Affordable Care Act: Alaska, Arkansas, Florida, Georgia, Kansas, Louisiana, Montana, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas and Wyoming.

ABOUT THE COALITION OF CORRECTIONAL HEALTH AUTHORITIES

The members of the Coalition of Correctional Health Authorities (CCHA) are the health authorities from the 50 states, six large jails and the Federal Bureau of Prisons. The head of corrections in each jurisdiction appoints his or her CCHA member and it is typically the person who reports directly to him or her on matters of health care. CCHA was founded on the idea of bringing together the health authorities to exchange promising practices in professional health care administration, to learn new and improved techniques in quality health care delivery, and to address critical emerging issues. The members of CCHA set their own rules of operation, meeting dates and training topics, among other things. CCHA conducts two business meetings each year (in conjunction with the ACA Winter Conference and Congress of Correction), an annual All Health Authority Training and an annual New Health Authority Training. For additional information about CCHA, please contact the ACA executive office at (703) 224-0102 or jenniferb@aca.org.

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REFERENCES

Buettgens, M., J. Holahan, and C. Carroll. Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid. *Urban Institute Timely Analysis*. March 2011.

Coalition of Correctional Health Authorities All Health Authority Training (May 22-25, 2011), St. Louis.

Colorado Health Care Reform — <http://www.colorado.gov/healthreform>

Delaware Health Care Commission — <http://dhss.delaware.gov/dhss/dhcc/>

Health Management Associates represented by Donna Strugar-Fritsch. (Oct. 25-26, 2011). Health Care Reform Working Group Meeting. Arlington, Va.

Heaton, B. (November 2011). States Face Health Benefits Exchange Deadline. *Government Technology*.

Louisiana Department of Insurance — <http://www.lidi.state.la.us/Health/HealthCareReform.html>

Michigan Health Care Reform — <http://www.michigan.gov/healthcarereform>

Mississippi Insurance Department — http://www.mid.state.ms.us/pages/health_care_reform.aspx

ADDITIONAL INFORMATION

American Correctional Association Resources

American Correctional Association: (800) 222-5646;
www.aca.org

Coalition for Correctional Health Authorities: (800) 222-5646
x0102

Health Care Committee: (800) 222-5646 x0102

Office of Correctional Health Care: (800) 222-5646 x0102

Office of Government and Public Affairs: (800) 222-5646 x0110

Government Organizations

Library of Congress:
<http://thomas.loc.gov/cgi-bin/bdquery/z?d111:h.r.03590>:

Substance Abuse and Mental Health Services Administration:
<http://www.samhsa.gov/healthreform/index.aspx>

U.S. Department of Health and Human Services:
www.healthcare.gov

U.S. Department of Justice: <http://www.justice.gov/healthcare/>

U.S. Department of Labor:
<http://www.dol.gov/ebsa/healthreform/>

U.S. Supreme Court:
<http://www.supremecourt.gov/docket/ppaaca.aspx>

White House:
<http://www.whitehouse.gov/healthreform/healthcare-overview>

Non-Governmental Organizations

American Medical Association: <http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/affordable-care-act.page>

Community Oriented Correctional Health Services:
http://www.cochs.org/health_reform

Health Care Reform GPS: www.healthreformgps.org

Kaiser Family Foundation: <http://www.kff.org/healthreform>

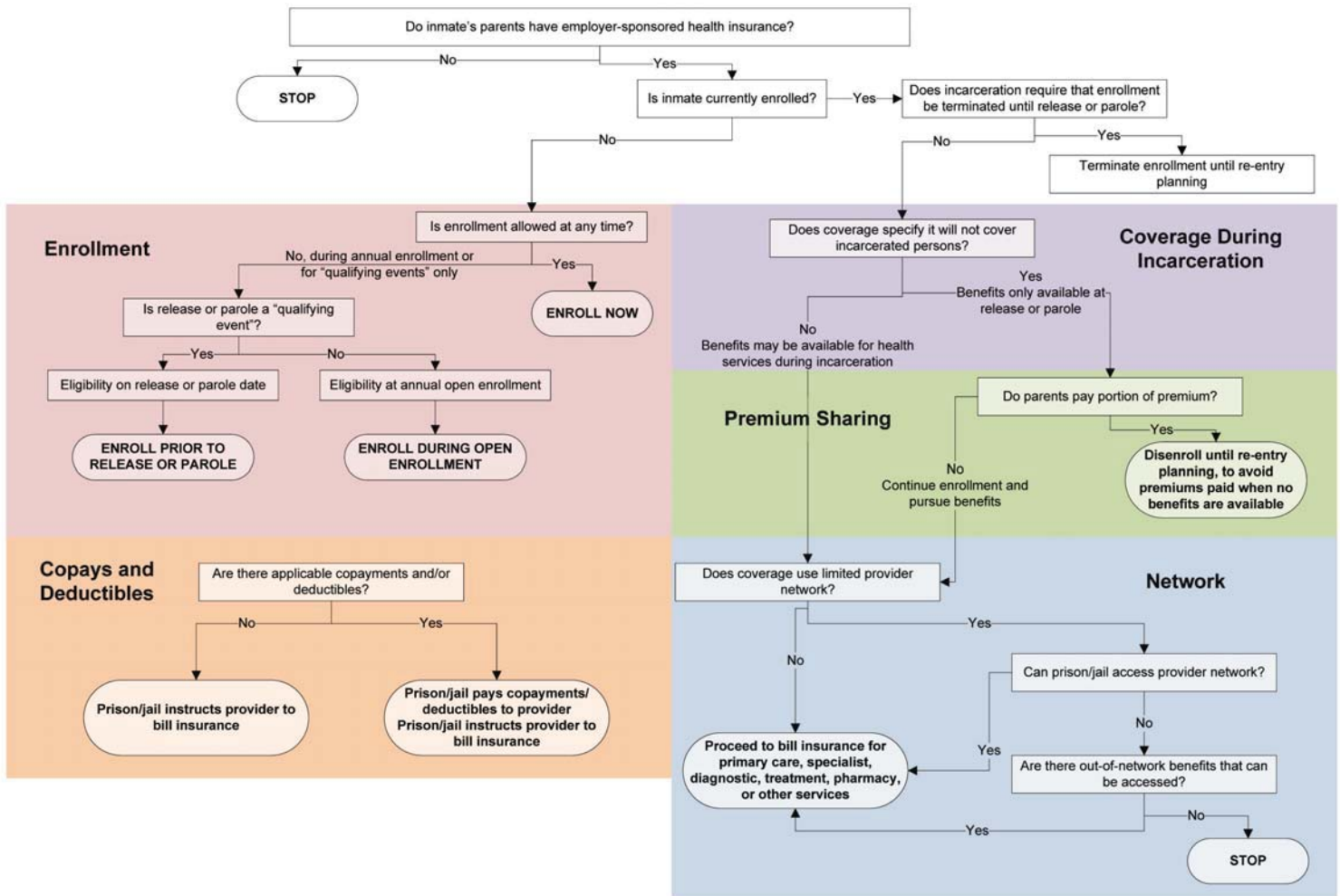
National Association of Insurance Commissioners & The
Center for Insurance Policy and Research:
http://www.naic.org/index_health_reform_section.htm

National Council of State Legislatures, State Legislation and
Challenges: <http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-aca.aspx>

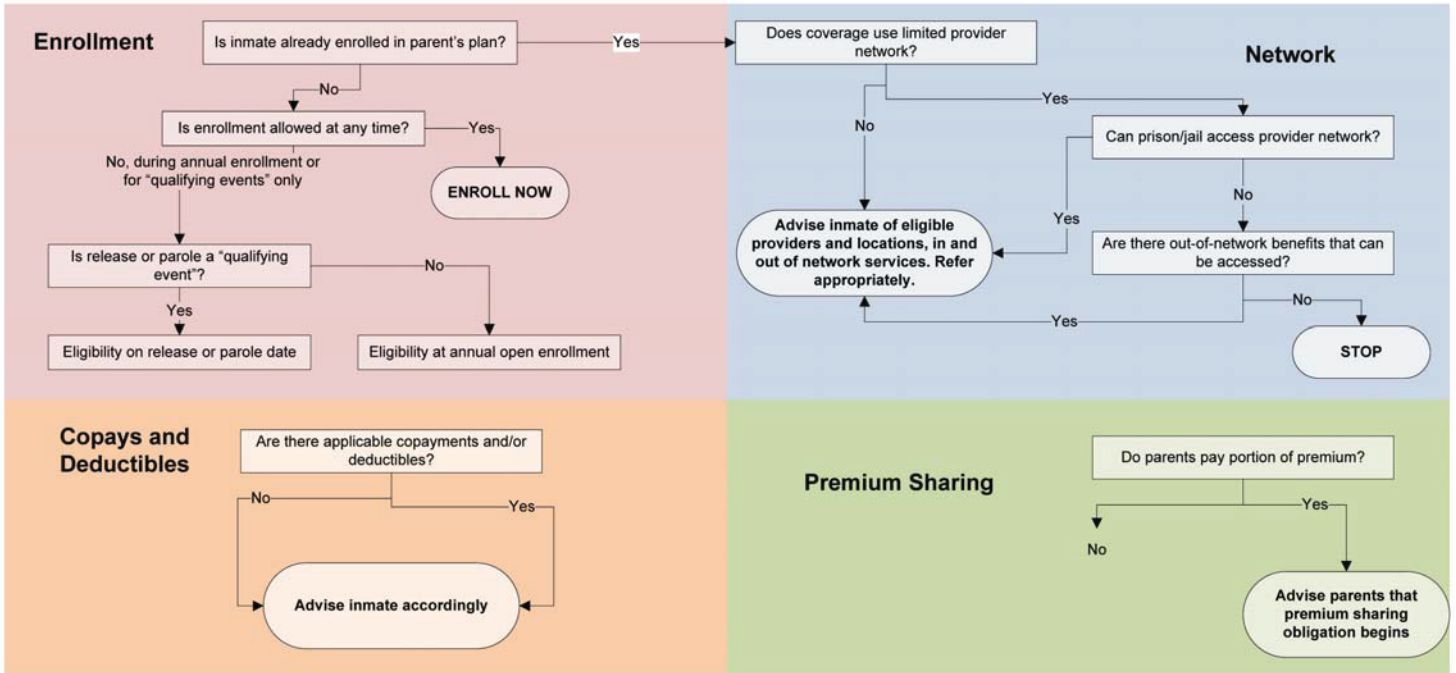
Robert Wood Johnson Foundation:
<http://www.rwjf.org/healthreform>

The Urban Institute, Health and Health Care:
<http://www.urban.org/health/index.cfm>

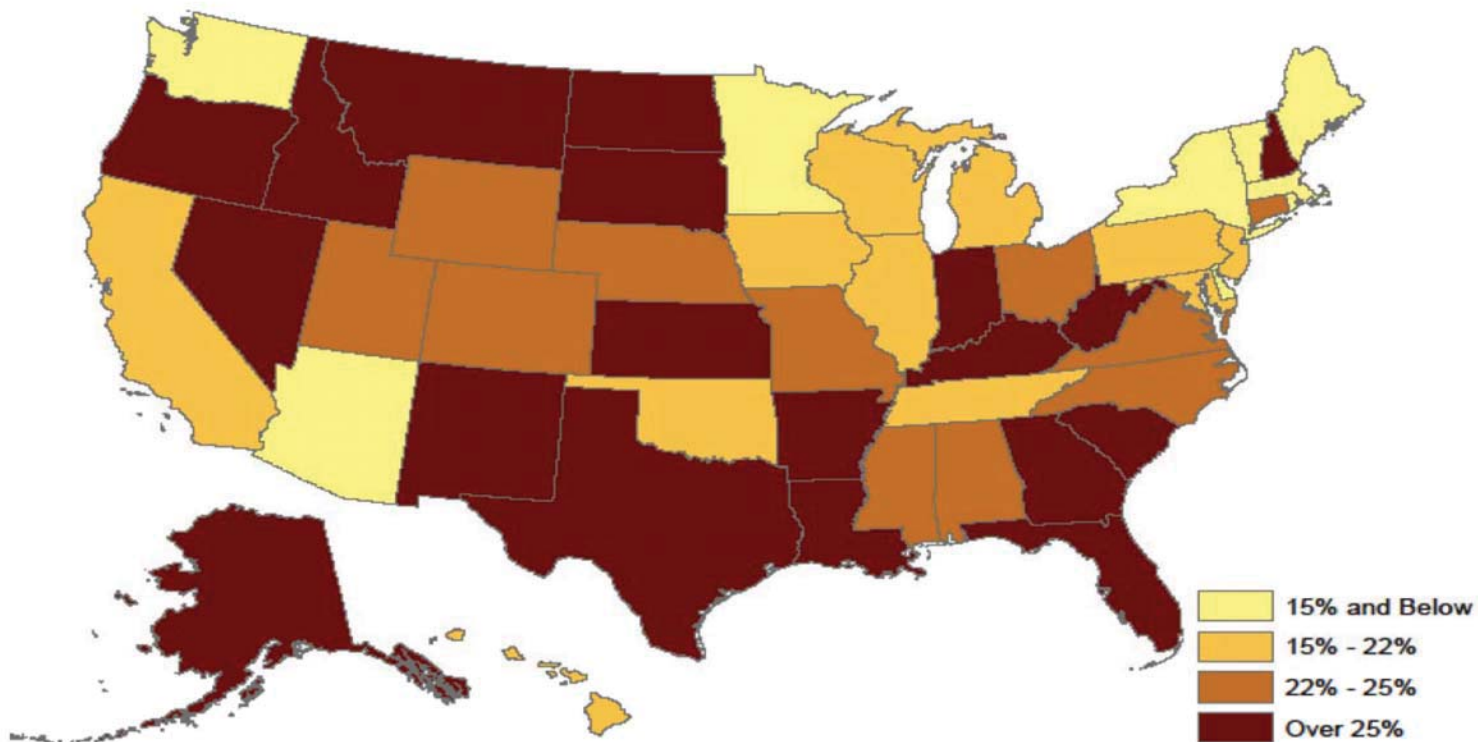
Below are algorithms to help illustrate the Affordable Care Act and what it means for the corrections field. The first will help corrections professionals determine health insurance coverage, enroll offenders, understand premiums and access provider networks. The second one addresses reentry planning, including enrollment, provider networks, copays and deductibles, and premium sharing.



Re-Entry Planning



New Medicaid Eligibles Enrolled as a Percentage of Total Enrollees







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